PRINTED: 12/18/2011

(X6) DATE

If continuation sheet 1 of 1

FORM APPROVED Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING_ TN3315 12/14/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 701 SEQUOYAH ROAD SODDY-DAISY HEALTH CARE CENTER SODDY-DAISY, TN 37379 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5)PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) N 000 Initial Comments N 000 During investigation of complaints #TN00028511 and #TN00029006 conducted on December 12 -14, 2011, at Soddy-Daisy Health Care Center, no deficiencies were cited under 1200-8-6 Licensure Standards of for Nursing Homes.

TITLE

VV5V11

ivision of Health Care Facilities

TATE FORM

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE